BREASTFEEDING Fact Sheet
An information update for WIC staff

CONTRACEPTION AND BREASTFEEDING

This fact sheet explains the impact of different methods of contraception on breastfeeding. It is not intended to provide information about risks or effectiveness of the methods or to replace a visit with a family-planning health professional. It is simply meant to give background information to WIC staff. A WIC participant who is interested in contraception methods should be referred to her physician or a family-planning clinic. WIC staff should never advise women about the type of contraception they should or should not use. If asked about the effect of contraceptives on breastfeeding, this information will be helpful.

PLANNING FOR CONTRACEPTION

Women should begin thinking about the method of contraception they will use postpartum while they are still pregnant. Although pregnancy is not likely to occur immediately after delivering, women may ovulate as soon as four to six weeks postpartum. Remember, a woman can ovulate and conceive before she resumes menstruation. She should have a plan for contraception in mind by the time of delivery.

CONTRACEPTION OPTIONS FOR BREASTFEEDING WOMEN

Breastfeeding women have several contraception options, including:

- Barrier methods such as condoms, cervical caps, the sponge and diaphragms;
- Vaginal spermicides such as gels, foams, films, creams, suppositories or tablets;
- Progestin-only methods such as the "mini-pill," Norplant and Depo-Provera;
- IUDs, such as the Copper T 380A or the Progestasert;
- The Lactational Amenorrhea Method (LAM), which is only temporarily effective; and
- Natural Family Planning (NFP) or Fertility Awareness Method (FAM).

More details on each of these methods follow.

BARRIER METHODS

The following methods are not likely to have a negative impact on breastfeeding.

- **Male and female condoms** are effective, safe contraceptive options. There are virtually no side effects with the possible exception of latex allergy when using male condoms. To increase the effectiveness of male condoms, use with a spermicide containing nonoxynol-9 (N-9). Condoms can help to protect against sexually transmitted infections (STIs), including human immunodeficiency virus (HIV).
- A **diaphragm**, used with N-9, is also a good method. Diaphragms should be refitted after a pregnancy, ideally at the six-week-postpartum visit. Diaphragms should also be refitted after any weight gain or loss of 10 or more pounds.
- **Cervical caps** also should be (re)fitted at the six-week-postpartum visit. Cervical caps are somewhat less effective in women who have had children.

▪ The **sponge**, which is available over the counter, also can be used after six weeks postpartum. Like the cap, the sponge is less effective for women who have had children. Some women find the high concentration of N-9 in the sponge to be irritating.

Diaphragms, cervical caps and sponges should be avoided if a woman has lochia, or postpartum discharge, as there is increased risk of toxic shock syndrome. Use of a diaphragm or the sponges may reduce risks for STIs.

VAGINAL SPERMICIDES

Spermicides, which come in many forms, have no negative impact on a woman's ability to breastfeed. Some animal studies show that N-9, the chemical used in spermicides available in the United States, is absorbed through the skin and secreted in breastmilk, but this has not been evaluated in humans yet.

Spermicides are often low cost, readily available, do not require a prescription and do not have long-term or systemic effects on the mother. In many cases, they are used in conjunction with a barrier method. When used alone, manufacturer's instructions should be followed exactly for maximum effectiveness.

Vaginal spermicide may also offer some protection (up to 25 percent) against some sexually transmitted diseases and may provide some lubrication. There has been no documentation that spermicides can protect against HIV. Some women find that N-9 can cause vaginal irritation. Spermicide should be reapplied before every occurrence of intercourse.

HORMONAL METHODS

People often wonder about the safety to the infant when the new mother uses the pill, minipill or combination pill during breastfeeding. While the steroids or hormones from oral contraceptives are secreted in breastmilk, the quantities are very small. In fact, they are about the same as the amount that is secreted by ovulatory mothers who are not using hormonal contraceptives. Nursing babies may also be exposed to these same types and levels of hormones if their mother becomes pregnant. Furthermore, dairy cows may be pregnant at the time of milking, so cow's milk and infant formula can also contain comparable levels of hormones.

There is no definitive answer on the impact of hormones on the baby, so the best conclusion that can be drawn at this point is that it is ideal to avoid combination oral contraceptives and to delay the start of any other hormonal method until six weeks postpartum.

Progestin-only methods such as the **minipills**, **Norplant, Depo-Provera** and **LNg 20** and **Progestasert IUDs,** are compatible with breastfeeding. Because these methods contain no estrogen, they do not impact the milk supply if started at six weeks postpartum.

All of these methods can have side effects for the mother, including weight gain, irregular menses and breast tenderness. None of the hormonal methods offer any protection against sexually transmitted infections.

Combination oral contraceptives, which contain both estrogen and progestin, **are NOT RECOMMENDED as the contraceptive of choice for breastfeeding women** due to the negative impact estrogen can have on the quantity of breastmilk. This is true even of the low-dose combinations. Should a woman have to use this method, it is best to delay starting the pills until about two to three months postpartum to give the milk supply time to become well established.

IUDS

IUDs have been out of favor in the past few years as a method of birth control. But, thanks in part to the recent controversy about their safety, newer methods have been developed with relatively little risk. The two currently available in the United States are the **Progestasert** and the **Copper T 380A.** A third, the **Levonorgestrel (LNg 20)**, is expected to be FDA approved and available by the year 2000. IUDs do not offer protection against sexually transmitted infections, but some may help to prevent pelvic inflammatory disease (PID).

"NATURAL" METHODS

These methods do not require any product or prescription but rely instead on the woman's learning about her body and applying this knowledge to her fertility. While these methods can be very effective, their effectiveness depends entirely on the skill with which they are practiced. None of these methods offer any protection against STIs.

▪ With **Lactational Amenorrhea Method (LAM)**, a woman relies on breastfeeding as a contraceptive. For some women, this can work very well. For others, it can be extremely unreliable. It is important to remember that women can ovulate and conceive while breastfeeding. This is especially likely if the baby is being supplemented in any way. The following four questions must be asked to determine the effectiveness of LAM:

1. Does the baby receive milk at the breast at least every four hours around the clock? (One sleep period of five to six hours is okay.)
2. Is the baby exclusively breastfed?
3. Is the mother amenorrheic (no vaginal bleeding) after 56 days postpartum?
4. Is the baby less than 6 months old?

If the mother can answer yes to these questions, she is less likely to get pregnant. If she answers no to even one, her chances of pregnancy are increased and she should not rely on breastfeeding as birth control.

▪ **Natural Family Planning (NFP)** and **Fertility Awareness Method (FAM)** usually are not recommended in the first six months postpartum. Due to hormonal changes during lactation, it is more difficult to monitor changes in cervical mucus. Also, a mother must get at least six hours of uninterrupted sleep in order to accurately record her basal body temperature, and this may be difficult when she has a young baby. Women who plan to use NFP/FAM while breastfeeding should contact their NFP/FAM instructor.

ADDITIONAL OPTIONS

Withdrawal, or removing the penis before ejaculation, is not often considered effective. However, if practiced carefully, it can be as effective as a diaphragm. Partner compliance is essential.

▪ **Abstinence** is 100% effective and has no negative impact on breastfeeding.

▪ **Tubal ligation** is an effective choice for women who do not plan on having more children. It can be done immediately postpartum and has no impact on breastfeeding.

POSTPARTUM SEXUALITY

Most women are advised to refrain from intercourse until after the six-week-postpartum checkup. In addition, women may find some of the following to be true:

▪ Perineal tenderness due to an episiotomy. Practicing with different positions might be more comfortable.

▪ Vaginal dryness, possibly due to hormonal changes from breastfeeding. A lubricant can help.

- Increased tiredness from the new demands of parenting can diminish sex drive.

- Breasts may leak milk in the early weeks when stimulated (due to the release of oxytocin in response to the stimulation). One way to stop the leaking is to apply direct pressure to the nipples with the palm of the hand.

References

Hatcher, Robert A., M.D., M.P.H., et al. 1998. *Contraceptive Technology*, 17th Revised Edition, New York: Ardent Media, Inc., pp. 589-614.